



HIPAA Privacy Authorization Form

Effective Date: _____ Student Name _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act-HIPAA , 45 C.F.R. Parts 160 and 164)

- 1. Authorization.** I authorize _____ (health care provider) to use and disclose the protected health information described below to the school health professionals (school nurses) for the educational entity known as Weldon City Schools - Weldon Elementary Global Academy (entity seeking the information).
- 2. Effective Period.** This authorization for release of information covers all past, present, and future periods of health care as long as the student is enrolled in Weldon City Schools or upon the written revocation or rights.
- 3. Extend of Authorization.** I authorize the release of the complete health records including records (excluding records related to family/relatives' history of mental or physical health)
- 4. Use.** This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation or other purposes as I may direct.
- 5. Termination.** This authorization shall be in force and effect until the withdrawal of the student from Weldon City Schools, at which time this authorization form expires.
- 6. Revocation Rights.** I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Print Full Name of Student/Patient _____

Patient's Signature _____
(if 18 years of age or older) _____ Date _____

Parent/Legal Guardian _____
_____ Date _____

PARENTS BILL OF RIGHTS

"§ 115C-76.45. Notifications of student physical and mental health. (a) The governing body of a public school unit shall adopt procedures to notify a parent of the following: (1) At the beginning of each school year, notice of each health care service offered at his or her child's school and the means for the parent to provide consent for any specific service. A parent's consent to a health care service does not waive the parent's right to access his or her child's educational records or health records or to be notified of changes in his or her child's services or monitoring.



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date _____, 20____

1. **THE PATIENT.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____, 20____

Student ID Number: _____

2. **AUTHORIZATION.** I authorize _____ ("Authorized Party/Medical Provider) to use or disclose the following: (check one)

- ☐ All of the above-mentioned patient's information
☐ The above-mentioned patient's medication information ONLY related to:

- ☐ The above-mentioned patient's medication information from
_____, 20 ____ to _____, 20 ____.

- ☐ Other

3. **DISCLOSURE.** The Authorized Party has my authorization to disclose Medical Records to (check one)

- ☐ School Health Professionals assigned to support the patient.
☐ ONLY the following party:

Name: _____

Address: _____

Phone (____) ____ - ____ Fax (____) ____ - ____

E-Mail: _____

4. **PURPOSE.** The reason for this authorization is: (check one)

- ☐ General Purpose. At my request (general)
☐ To Review Medical Records to understand the student/patient's health needs, supports needed in school, obtain immunization records, expected school attendance and create/update the student/patient's Health Care Plan(s).

5. **TERMINATION.** This authorization will terminate upon withdrawal from Weldon City Schools or upon sending a written revocation to the Authorization Party.



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6. ACKNOWLEDGEMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless records are sought to complete an assessment to provide treatment while at school and to develop an appropriate health plan(s)).

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient if 18 years or older _____

Date

Print Name _____

IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW.

The Patient is unable to sign due to: (check one)

☐ **Being a Minor.** The patient is _____ years old and considered a minor under state law.

☐ **Being Incapacitated.** Patient is incapacitated due to: _____

☐ **Other** _____

Signature of Representative _____

Date

Print Name _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other:



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